Arizona Health Care Cost Containment System

May-June, 2003

ENCOUNTER KEYS

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AHCCCS ENCOUNTER

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Physician Fee Schedule

This year, in response to provider network concerns regarding the Medicare Physician Fee Schedule updates, the potential for additional adjustments to Medicare's 2003 rates, and the current budget situation in Arizona, AHCCCS froze the current physician fee schedule rates, thus implementing a 0% update for those physician fees typically updated on April 1.

AHCCCS is however, adding or updating rates for 485 procedure codes on the AHCCCS fee schedule effective for dates of service on and after April 1, 2003. This update includes:

- Rates for 320 new procedure codes,
- Rates for 50 procedure codes previously priced "by report",
- Rates for 115 procedure codes receiving adjustments in relation to the quarterly DME updates.

The AHCCCS fee schedule and procedure modifiers, incorporating the updates described above, may be accessed on the FTP server by referencing file #02 at ftp/shareinfo/reference/refer02.zip following the April 2003 month-end processing in early May 2003. In addition, the fee schedule will be available on the AHCCCS website, located at www.ahcccs.state.az.us. By clicking on the Provider section, you can view the entire fee schedule or groups of procedure codes. Rates are downloadable from the website as text or Excel files, and are searchable by both procedure code and description. The website will be updated by the end of April.

If you have any questions concerning the AHCCCS fee schedule, please call Victoria Burns at (602) 417-4049, or if outside Maricopa County (800) 654-8713 ext.7-4049.

DENTAL COVERAGE CHANGES

Effective July 1, 2003, the Arizona Health Care Cost Containment System (AHCCCS) will no longer separately reimburse dental providers for codes D1310 (Nutritional Counseling) or D1330 (Oral Hygiene Instruction). Discussion of general nutrition and oral hygiene instruction is considered included as part of routine dental exams, and should be reported as that. AHCCCS has also re-opened CDT-3 codes that had been closed on April 1, 2003. Codes deleted in the CDT-4 will be kept open until September 30, 2003.

DILEMMAS

For the months of May and June the following error code conditions are not subject to sanction.

S385 – Service Units Exceed Maximum Allowed (80000 procedure codes and service units less than twice the limit).

P015 - Service Provider Type Invalid For Uniform Billing Form (applies to the new provider types A1, A2, A3, A5, B1, B2, B3, B5, B6, B7)

S386 – Maximum Anesthesia Units Exceeded (Service units less than twice the limit)

ERROR CODE V151 & V152

There has been some confusion in regards to the [V151 (OR RM Bill-ICD9 And/Or HCPCS Must = Surgical) and V152 (OR RM Bill-No Surgical ICD9 And/Or HCPCS Code Present)] error codes that were turned hard on April 1, 2003. The following explains the logic for these codes:

When reporting a 36X revenue code a surgical ICD9 procedure code is required.

If a 36X revenue code is reported without a surgical ICD9 procedure code, a V152 (no surgical ICD9 code present) encounter pend error results.

If a 36X revenue code is reported with a non-surgical ICD9 procedure code, a V151 (ICD9 must be surgical) encounter pend error results. If the non-surgical ICD9 procedure code is correct, the 36X charges must be non-covered to clear the pend error.

UPDATES

Provider Type to Procedure Codes

Effective with dates of service on and after July 1, 2002 the following CPT/HCPCS codes can be reported by provider type 10-Podiatrist:

- 27892-Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
- 27640-Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis or exostosis); tibia
- 27707-Osteotomy; fibula
- 27647-Radical resection of tumor, bone; talus or calcaneus
- 20692-Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, llizarov, Monticelli type)
- 27691-Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)
- 20693-Adjustment or revision of external fixation system requiring anesthesia (eg, new pin(s) or wire(s) and/or new ring(s) or bar(s))
- A5500-For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe
- A5501-For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe
- A5509-For diabetics only, direct formed, molded to foot with external heat source (i.e. heat gun) multiple density insert(s), prefabricated, per shoe
- A5511-For diabetics only, custom-molded from model of patient's foot, multiple density insert(s), custom-fabricated, per shoe
- A6196-Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing

Provider type 07 – Dentist/Oral Surgeon

The following procedure codes have been added to the provider type 07 – Dentist/Oral Surgeon with an effective date of 01/01/2002.

12011 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12013 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12014 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12015 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12016 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12017 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12018 Simple Repair Of Superficial Wounds Of Face, Ears, Eyelids, Nose,
12020 Treatment Of Superficial Wound Dehiscence; Simple Closure
12021 Treatment Of Superficial Wound Dehiscence; With Packing
12051 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 2.5 cm or less
12052 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 2.6 cm to 5.0 cm
12053 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 5.1 cm to 7.5 cm
12054 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 7.6 cm to 12.5 cm
12055 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 12.6 cm to 20.0 cm
12056 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; 20.1 cm to 30.0 cm
12057 Layer Closure Of Wounds Of Face, Ears, Eyelids, Nose, Lips And/Or Mucous Membranes; over 30.0 cm
13131 Repair, Complex, Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia
13132 Repair, Complex, Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia
13133 Repair, Complex, Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia
13150 Repair, Complex, Eyelids, Nose, Ears And/Or Lips; 1.0 cm Or Less
13151 Repair, Complex, Eyelids, Nose, Ears And/Or Lips; 1.1 cm To 2.5 cm
13152 Repair, Complex, Eyelids, Nose, Ears And/Or Lips; 2.6 cm To 7.5 cm
13153 Repair, Complex, Eyelids, Nose, Ears And/Or Lips; Each Additional
13160 Secondary Closure Of Surgical Wound Or Dehiscence, Extensive Or Complicated
14040 Adjacent Tissue Transfer Or Rearrangement, Forehead, Cheeks, Chin
14041 Adjacent Tissue Transfer Or Rearrangement, Forehead, Cheeks, Chin
14060 Adjacent Tissue Transfer Or Rearrangement, Eyelids, Nose, Ears And/Or lips; defect 10 cm or less
14061 Adjacent Tissue Transfer Or Rearrangement, Eyelids, Nose, Ears And/Or lips; defect 10.1 cm to 30.0 cm
14300 Adjacent Tissue Transfer Or Rearrangement, More Than 30 sq cm,

Q2008 & J3490 Two injection codes, earlier announced as rate updates for April 1, 2003, have received rate adjustments. The rate for Q2008 is $10.89, effective for dates of service on and after April 1, 2003. J3490 will continue to be paid "By Report", effective for dates of service on and after March 1, 1989.

25260—(Repair, Tendon Or Muscle, Flexor, Forearm And/Or Wrist) can now be billed with a Place of Service 23—Emergency Room - Hospital

V50.2—Hospitals should report non-covered routine or non-medically necessary newborn circumcisions with diagnosis code of V50.2. All related charges must be reported in the non-covered charge field. Medically necessary circumcisions should continue to be reported as covered services.

General Information:

In the communication e-mail, dated March 28, 2003, it stated that the maximum age limit was changed on CPT code 92135. This information was incorrect. Please see statement below for correct information on this CPT code and new information on the PreGen-26;

- Heidelberg Tomography (CPT 92135)

  Review of literature in regards to this procedure suggests that this technique has some limited applications. It is considered acceptable medical practice for monitoring and evaluation of patients with diagnosis of glaucoma. AHCCCS will pend claims for medical review in AHCCCS fee-for-service members less than 18 years of age.

- PreGen-26

  After review of current literature, the test has not, as yet, been adopted as a community standard of care. Therefore, at this time AHCCCS does not consider this a covered service.

MEMBER VERIFICATION

Please Note that changes to the AHCCCS PMMIS and automated Member Eligibility Verification System (MEVS) have been revised.

On PMMIS, if the Date of Service on the Primary ID has enrollment into FFS and the Secondary ID has enrollment into a health plan, the Primary ID will display the word "SECOND"". This will prompt you to check the Secondary ID for enrollment information. For FFS periods not covered by the Secondary ID enrollment, the health plan ID will continue to display the Health Plan ID of "008690, 003335, etc".

Medifax now has warning messages that tell you the record you are attempting to verify has a Primary ID or a Secondary ID. Medifax has also been changed to display the verification information when it is requested on the Secondary ID.

The messages are:

Secondary ID**: "Warning Information: The AHCCCS ID entered is a Secondary AHCCCS ID. Correct AHCCCS ID IS: ######### "** Medifax will then furnish the requested information on the Secondary ID Record.

Primary ID: **"Warning Information: The AHCCCS ID entered has a Linked Secondary AHCCCS ID: ######### "** Medifax will then furnish the requested information. If the health plan on the Primary ID Record was in FFS status, the health plan will display the word **"SECOND"** and a message to **"Check Secondary for Enrollment".**